FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046003

Facility Name: Warren Barr Pavilion

Address: 66 West Oak Street (Number) Chicago (City) 60610 (Zip Code)

County: Cook

Telephone Number: (312) 337-5400 **Fax #** ( )

IDPA ID Number: 36-2171705

Date of Initial License for Current Owners: 07/01/77

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 503(c)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title) Steven N. Lavenda, CPA	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	19,032	1
2		Skilled Pediatric (SNF/PED)			2
3	242	Intermediate (ICF)	242	88,572	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	294	TOTALS	294	107,604	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,015	1,719	6,436	9,170	8
9	SNF/PED					9
10	ICF	21,951	33,411	1,546	56,908	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,966	35,130	7,982	66,078	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.41%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 52 and days of care provided 6,436

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: N/A Fiscal Year: N/A

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	532,828	50,427	9,722	592,977		592,977		592,977			1
2	Food Purchase		515,855		515,855		515,855	(68,983)	446,872			2
3	Housekeeping	378,802	27,570	9,042	415,414		415,414	(5,597)	409,817			3
4	Laundry	89,836	102,819		192,655		192,655		192,655			4
5	Heat and Other Utilities			300,170	300,170		300,170	(12,714)	287,456			5
6	Maintenance	23,679	54,204	101,414	179,297		179,297	(187)	179,110			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,025,145	750,875	420,348	2,196,368		2,196,368	(87,481)	2,108,887			8
	B. Health Care and Programs											
9	Medical Director			16,091	16,091		16,091	(191)	15,900			9
10	Nursing and Medical Records	3,297,609	213,454	231,342	3,742,405		3,742,405	(31,450)	3,710,955			10
10a	Therapy	168,974			168,974		168,974		168,974			10a
11	Activities	120,945	47,785	165	168,895		168,895	(37,850)	131,045			11
12	Social Services	168,792	918	375	170,085		170,085		170,085			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,756,320	262,157	247,973	4,266,450		4,266,450	(69,491)	4,196,959			16
	C. General Administration											
17	Administrative			229,332	229,332		229,332	(81,459)	147,873			17
18	Directors Fees											18
19	Professional Services			43,176	43,176		43,176	44,600	87,776			19
20	Dues, Fees, Subscriptions & Promotions			58,245	58,245		58,245	(16,530)	41,715			20
21	Clerical & General Office Expenses	149,854	13,149	226,742	389,745		389,745	(100,203)	289,542			21
22	Employee Benefits & Payroll Taxes			599,019	599,019		599,019		599,019			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,464	6,464		6,464	3,870	10,334			24
25	Other Admin. Staff Transportation			1,626	1,626		1,626		1,626			25
26	Insurance-Prop.Liab.Malpractice			100,000	100,000		100,000		100,000			26
27	Other (specify):*							29,459	29,459			27
28	**TOTAL General Administration**	149,854	13,149	1,264,604	1,427,607		1,427,607	(120,263)	1,307,344			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,931,319	1,026,181	1,932,925	7,890,425		7,890,425	(277,235)	7,613,190			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Warren Barr Pavilion **0046003**

COST REPORT RECLASSIFICATIONS

07/01/99

06/30/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2	FOOD		

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number Warren Barr Pavilion #0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,100,250	1,100,250		1,100,250	41,416	1,141,666			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,927	182,927		182,927	(116,582)	66,345			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,203	16,203		16,203		16,203			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,299,380	1,299,380		1,299,380	(75,166)	1,224,214			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		679,687	239,516	919,203		919,203	120,271	1,039,474			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,820	1,820		1,820		1,820			41
42	Provider Participation Fee			161,406	161,406		161,406		161,406			42
43	Other (specify):*	101,209	27,522	21,420	150,151		150,151	(92,585)	57,566			43
44	**TOTAL Special Cost Centers**	101,209	707,209	424,162	1,232,580		1,232,580	27,686	1,260,266			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,032,528	1,733,390	3,656,467	10,422,385		10,422,385	(324,715)	10,097,670			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (145,452)	43	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(68,983)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	41,416	30		9
10	Interest and Other Investment Income	(112,404)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,449)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,400)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(97,635)	21		24
25	Fund Raising, Advertising and Promotional	(7,765)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(112,298)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (512,970)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	188,255		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 188,255		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (324,715)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Warren Barr Pavilion

ID# 0046003

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Housekeeping	$ (5,597)	3	1
2	Non-Care Utilities	(3,887)	5	2
3	Non-Care Maintenance	(187)	6	3
4	Patient Trust Fund Interest	(1,729)	32	4
5	Employee Parking Revenue (To Expense Portion)	(4,699)	43	5
6	Miscellanous Income	(4,741)	21	6
7	Life Enrichment Program (To Expense Portion)	(37,850)	11	7
8	CHAPS Income (To Expense Portion)	(36,016)	10	8
9	Community Relations	(8,765)	20	9
10	Cable Television	(8,827)	5	10
11				11
12				12
13				13
14				14
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89				89
90	**Total**	(112,298)		90

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Warren Barr Pavilion **#** 0046003 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(68,983)	0	0	0	0	0	0	0	0	0	0	(68,983)	2
3	Housekeeping	(5,597)	0	0	0	0	0	0	0	0	0	0	(5,597)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,714)	0	0	0	0	0	0	0	0	0	0	(12,714)	5
6	Maintenance	(187)	0	0	0	0	0	0	0	0	0	0	(187)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(87,481)	0	0	0	0	0	0	0	0	0	0	(87,481)	8
	B. Health Care and Programs													
9	Medical Director	0	(191)	0	0	0	0	0	0	0	0	0	(191)	9
10	Nursing and Medical Records	(36,016)	4,566	0	0	0	0	0	0	0	0	0	(31,450)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(37,850)	0	0	0	0	0	0	0	0	0	0	(37,850)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(73,866)	4,375	0	0	0	0	0	0	0	0	0	(69,491)	16
	C. General Administration													
17	Administrative	0	(81,459)	0	0	0	0	0	0	0	0	0	(81,459)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,400)	52,000	0	0	0	0	0	0	0	0	0	44,600	19
20	Fees, Subscriptions & Promotions	(16,530)	0	0	0	0	0	0	0	0	0	0	(16,530)	20
21	Clerical & General Office Expenses	(102,376)	2,173	0	0	0	0	0	0	0	0	0	(100,203)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,870	0	0	0	0	0	0	0	0	0	3,870	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	29,459	0	0	0	0	0	0	0	0	0	29,459	27
28	**TOTAL General Administration**	(126,306)	6,043	0	0	0	0	0	0	0	0	0	(120,263)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(287,653)	10,418	0	0	0	0	0	0	0	0	0	(277,235)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Warren Barr Pavilion # 0046003 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	41,416	0	0	0	0	0	0	0	0	0	0	41,416	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(116,582)	0	0	0	0	0	0	0	0	0	0	(116,582)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(75,166)	0	0	0	0	0	0	0	0	0	0	(75,166)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	120,271	0	0	0	0	0	0	0	0	0	120,271	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(150,151)	57,566	0	0	0	0	0	0	0	0	0	(92,585)	43
44	**TOTAL Special Cost Centers**	(150,151)	177,837	0	0	0	0	0	0	0	0	0	27,686	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(512,970)	188,255	0	0	0	0	0	0	0	0	0	(324,715)	45

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois Masonic Medical Center	100%	IMMC - Warren N. Barr Pavilion	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	IMMC Administrative Fees	$ 118,800	Illinois Masonic Medical Center	100.00%	$ 78,230	$ (40,570)	1
2	V	17	IMMC Accounting Fees	110,532	Illinois Masonic Medical Center	100.00%	69,643	(40,889)	2
3	V	19	Professional Fees		Illinois Masonic Medical Center	100.00%	52,000	52,000	3
4	V	27	Employee Benefits-Administrative		Illinois Masonic Medical Center	100.00%	29,459	29,459	4
5	V	9	Medical Director	16,091	Illinois Masonic Medical Center	100.00%	15,900	(191)	5
6	V	39	Physical Therapy	100,189	Illinois Masonic Medical Center	100.00%	168,321	68,132	6
7	V	39	Occupational Therapy	88,301	Illinois Masonic Medical Center	100.00%	129,347	41,046	7
8	V	39	Speech Therapy	51,026	Illinois Masonic Medical Center	100.00%	62,119	11,093	8
9	V	10	Therapy Medical Supplies		Illinois Masonic Medical Center	100.00%	4,566	4,566	9
10	V	21	Therapy Office Supplies		Illinois Masonic Medical Center	100.00%	2,173	2,173	10
11	V	24	Therapy Professional / Education		Illinois Masonic Medical Center	100.00%	3,870	3,870	11
12	V	43	Employee Benefits-Therapy		Illinois Masonic Medical Center	100.00%	57,566	57,566	12
13	V	26	General Insurance	100,000	Illinois Masonic Medical Center	100.00%	100,000		13
14	Total			$ 584,939			$ 773,194	$ * 188,255	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$ 4,566	$ 4,566	15
16	V						100,000	100,000	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 104,566	$ * 104,566	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Illinois Masonic Medical Center
Street Address: 836 W. Wellington Avenue
City / State / Zip Code: Chicago, Illinois 60657-5193
Phone Number: ((312) 337-5400
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrator	Full Time Equivalents	100	2	$ 104,307	$ 104,307	75	$ 78,230	1
2	17	V/P of Finance	Full Time Equivalents	100	2	92,857	92,857	75	69,643	2
3	19	Accounting	Full Time Equivalents	100	2	30,000	30,000	50	15,000	3
4	19	Support	Full Time Equivalents	100	1	20,000	20,000	100	20,000	4
5	19	Administrative Expense	Direct Cost	100	1	5,000		100	5,000	5
6	19	Audit Expense	Direct Cost	100	1	6,000		100	6,000	6
7	19	Computer Support Expense	Direct Cost	100	1	6,000		100	6,000	7
8	27	Employee Benefits-Administrative	Direct Cost	100	1	29,459		100	29,459	8
9	9	Medical Director	Direct Cost	100	1	15,900		100	15,900	9
10	39	Physical Therapy	Full Time Equivalents	100	1	168,321	168,321	100	168,321	10
11	39	Occupational Therapy	Full Time Equivalents	100	1	129,347	129,347	100	129,347	11
12	39	Speech Therapy	Full Time Equivalents	100	1	62,119	62,119	100	62,119	12
13	10	Therapy Medical Supplies	Direct Cost	100	1	4,566		100	4,566	13
14	21	Therapy Office Supplies	Direct Cost	100	1	2,173		100	2,173	14
15	24	Therapy Professional / Education	Direct Cost	100	1	3,870		100	3,870	15
16	43	Employee Benefits-Therapy	Direct Cost	100	1	57,566		100	57,566	16
17	26	General Insurance		100	2	100,000		100	100,000	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 837,485	$ 606,951		$ 773,194	25

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IHFA Bond Issue			Refinance Mortgage		11/18/93	$ 3,345,382	$ 2,920,272		7.43 & .03	$ 181,198	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,345,382	$ 2,920,272			$ 181,198	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income										(112,404)	12
13	Non-Care Related Interest	X		Building Space Rented - IMMC							(2,449)	13
14	TOTAL Non-Facility Related						$	$			$ (114,853)	14
15	TOTALS (line 9+line14)						$ 3,345,382	$ 2,920,272			$ 66,345	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,152 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 9

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	103,152		$ 740,000	1
2					2
3	TOTALS	103,152		$ 740,000	3

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	294		1976	9/30/1975	$ 4,969,910	$ 124,248	30	$ 165,664	$ 41,416	$ 3,054,424	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various Renovations			9/30/1976	1,379						9
10	Various Renovations			9/30/1977	104,718						10
11	Various Renovations			9/30/1978	5,239						11
12	Various Renovations			9/30/1979	507,498						12
13	Various Renovations			9/30/1980	29,634						13
14	Various Renovations			9/30/1981	101,628						14
15	Various Renovations			9/30/1982	199,096						15
16	Various Renovations			9/30/1983	262,114						16
17	Various Renovations			9/30/1984	547,584						17
18	Various Renovations			9/30/1985	485,112						18
19	Various Renovations			9/30/1986	296,094						19
20	Various Renovations			9/30/1987	605,895						20
21	Various Renovations			9/30/1988	98,646						21
22	Various Renovations			9/30/1989	491,164						22
23	Various Renovations			9/30/1990	1,277,966						23
24	Various Renovations			9/30/1991	198,481						24
25	Various Renovations			9/30/1992	834,421						25
26	Various Renovations			9/30/1993	464,767						26
27	Various Renovations			9/30/1994	2,552,777						27
28	3rd Floor Renovations			9/30/1995	1,190,254						28
29	Patient Room Renovations (Floors 4,6,7, and 8)			6/30/1996	273,645						29
30	Replace Fire Alarm System			6/30/1996	198,474						30
31	Page 12A				3,803,564						31
32	Page 12B				604,231						32
33											33
34											34
35	Depreciation					757,213		757,213		7,393,930	35
36	TOTAL (lines 4 thru 35)				$ 20,104,291	$ 881,461		$ 922,877	$ 41,416	$ 10,448,354	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install New Emergency Generator			6/30/1996	452,335						9
10	Install Security Gates			6/30/1996	16,848						10
11	Renovations (Floor 5)			6/30/1996	34,845						11
12	Renovations - 4 Patient Rooms			6/30/1997	125,367						12
13	Fire Alarm System			6/30/1997	65,669						13
14	Emergency Power System			6/30/1997	46,326						14
15	Laundry Room			6/30/1997	52,022						15
16	Renovations (Floor 4)			6/30/1997	1,957,958						16
17	External Sign			6/30/1997	71,074						17
18	Renovations - Administrative			6/30/1997	950						18
19	Renovations - 3 Patient Rooms			6/30/1998	183,572						19
20	Renovations (Floor 9)			6/30/1998	11,522						20
21	Laundry Room			6/30/1998	20,867						21
22	Renovations - Engineering Office			6/30/1998	2,565						22
23	Renovations (Floor 4)			6/30/1998	10,796						23
24	External Sign			6/30/1998	7,217						24
25	Renovations (Floor 7)			6/30/1998	35,882						25
26	Sleep Lab			6/30/1998	3,272						26
27	Renovations (Floor 5)			6/30/1998	34,555						27
28	Hot Water Heater			6/30/1998	18,763						28
29	Renovations to Rooms (Floors 4, 6, 7 and 8)			6/30/1999	266,830						29
30	Renovations - Survey			6/30/1999	58,178						30
31	Replace Pulper			6/30/1999	27,816						31
32	Renovations (Floor 8)			6/30/1999	16,200						32
33	General Constructions			6/30/2000	208,985						33
34	Painting and Wallpapering			6/30/2000	52,221						34
35	Millwork (Countertops, Doors, Frames, Etc.)			6/30/2000	20,929						35
36	TOTAL (lines 4 thru 35)				$ 3,803,564	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Mini Blinds and Valances			6/30/1999	765						9
10	Mini Blinds and Valances			6/30/1999	765						10
11	Mini Blinds and Valances			6/30/1999	765						11
12	Mini Blinds and Valances			6/30/1999	765						12
13	General Construction			6/30/2000	101,479						13
14	Painting and Wallpapering			6/30/2000	77,384						14
15	Millwork (Counter Tops, Doors, Frames, Etc.)			6/30/2000	53,160						15
16	Flooring			6/30/2000	32,902						16
17	Flooring			6/30/2000	32,902						17
18	Electrical Work			6/30/2000	45,735						18
19	HVAC			6/30/2000	21,060						19
20	Workstation			6/30/2000	5,685						20
21	Flooring			6/30/2000	5,531						21
22	Flooring			6/30/2000	5,531						22
23	Electical Work			6/30/2000	29,024						23
24	HVAC			6/30/2000	84,973						24
25	Cubicle Tracks			6/30/2000	31,558						25
26	Cubicle Tracks			6/30/2000	31,558						26
27	Nurse-On Call System			6/30/2000	31,645						27
28	Drapes			6/30/2000	460						28
29	Drapes			6/30/2000	1,777						29
30	Steamer			6/30/2000	5,531						30
31	Security Cameras			6/30/2000	3,276						31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 604,231	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,478,465	$ 202,312	$ 202,312	$	10	$ 1,529,532	37
38	Current Year Purchases	146,879	11,021	11,021		10	11,021	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 2,625,344	$ 213,333	$ 213,333	$		$ 1,540,553	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	1998 Chrysler Sebring	1998	$ 21,822	$ 5,456	$ 5,456	$	4	$ 13,639	42
43										43
44										44
45										45
46	TOTALS			$ 21,822	$ 5,456	$ 5,456	$		$ 13,639	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	23,491,457	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	1,100,250	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	1,141,666	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	41,416	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	12,002,546	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Renovations (Floor 8)	$ 104,847	58
59			59
60			60
61		$ 104,847	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Warren Barr Pavilion **0046003**

RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE

06/30/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Warren N. Barr Pavilion	2,478,465	202,312	202,312	-	1,529,532
				-	
				-	
				-	
				-	
				-	
				-	
TOTALS	2,478,465	202,312	202,312	-	1,529,532
LINE 29: CURRENT YEAR					
Warren N. Barr Pavilion	146,879	11,021	11,021	-	11,021
				-	
				-	
				-	
				-	
				-	
				-	
TOTALS	146,879	11,021	11,021	-	11,021
LINE 30: FULLY DEPRECIATED					
Warren N. Barr Pavilion			-	-	
				-	
				-	
				-	
				-	
				-	
				-	
TOTALS	-	-	-	-	-

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 2,559 Description: Artificial Plants
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Recreational Therapy	1994 Ford Aerotech	$ 1,137	$ 13,644	17
18					18
19					19
20					20
21	TOTAL		$	$ 13,644	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 88,301	$		$ 88,301	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			51,026			51,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			100,189			100,189	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				605,481		605,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					0	74,206		74,206	13
14	TOTAL			$		$ 239,516	$ 679,687		$ 919,203	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	46,710
2	Outside Lab Service	27,496
3		
4		
5		
6		
7		
8		
9		
10		
		74,206

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,163,182	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 325,000)	1,287,483		3
4	Supply Inventory (priced at)	38,523		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,252		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	2,569		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,493,009	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	740,000		13
14	Buildings, at Historical Cost	4,969,910		14
15	Leasehold Improvements, at Historical Cos	14,603,061		15
16	Equipment, at Historical Cost	2,764,832		16
17	Accumulated Depreciation (book methods)	(11,961,131)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	104,847		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,221,519	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,714,528	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 625,872	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	407,280		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	347,344		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,105		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	703,074		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,090,675	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,920,272		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,920,272	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,010,947	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,703,581	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,714,528	$	48

***(See instructions.)**

Facility Name & ID Number Warren Barr Pavilion **#** 0046003 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 06/30/00

OTHER CURRENT ASSETS:	Amount	Amount
Interest Receivable	2,569	
	2,569	

OTHER CURRENT LIABILITIES:	Amount	Amount
Due to IMMC	510,069	
Medicare C/R Settlements	192,855	
Payroll Advances	150	
	703,074	

OTHER NON CURRENT ASSETS:		
Construction In Progress	104,847	
	104,847	

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,469,408	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,469,408	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	234,173	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 234,173	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 12,703,581	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	Warren Barr Pavilion	#	0046003	Report Period Beginning:	07/01/99	Ending:	**06/30/00**

Balance per General Ledger		12,469,408
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		12,469,408
Equity(Deficit) from Page 17 Col 1		12,703,581
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		12,703,581

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,774,172	1
2	Discounts and Allowances for all Levels	(1,449,729)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,324,443	3
	B. Ancillary Revenue		
4	Day Care	186,735	4
5	Other Care for Outpatients		5
6	Therapy	732,168	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 918,903	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,100	12
13	Barber and Beauty Care	8,613	13
14	Non-Patient Meals	68,983	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	72,504	16
17	Sale of Drugs	552,753	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,379	19
20	Radiology and X-Ray		20
21	Other Medical Services	268,539	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 1,011,871	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	287,316	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 287,316	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	114,025	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 114,025	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,656,558	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,196,368	31
32	Health Care	4,266,450	32
33	General Administration	1,427,607	33
	B. Capital Expense		
34	Ownership	1,299,380	34
	C. Ancillary Expense		
35	Special Cost Centers	1,071,174	35
36	Provider Participation Fee	161,406	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,422,385	40
41	**Income before Income Taxes (line 30 minus line 40)****	234,173	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 234,173	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **Warren Barr Pavilion** **# 0046003** **Report Period Beginning:** **07/01/99** **Ending:** **06/30/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
06/30/00

	DESCRIPTION	AMOUNT
1	Misc. Income (Adjusted Out - Page 5)	4,741
2	Life Enrichment Program (Adjusted Out to Expense - Page 5)	48,750
3	CHAPS Revenue (Adjusted Out to Expense - Page 5)	41,520
4	Diabetic Monitering	5,668
5	Vending Commission	3,911
6	Employee Parking Revenue (Adjusted Out To Expense - Page 5)	9,435
7		
8		
9		
10		
11		
12		
13		
14		
15		
	TOTALS	114,025

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,946	3,189	$ 90,274	$ 28.31	1
2	Assistant Director of Nursing	1,864	1,920	54,322	28.29	2
3	Registered Nurses	34,040	43,094	1,073,812	24.92	3
4	Licensed Practical Nurses	29,935	37,507	585,814	15.62	4
5	Nurse Aides & Orderlies	135,770	165,235	1,472,352	8.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,801	13,261	168,974	12.74	8
9	Activity Director	1,888	2,080	31,439	15.11	9
10	Activity Assistants	10,630	12,076	89,506	7.41	10
11	Social Service Workers	10,717	12,329	168,792	13.69	11
12	Dietician	1,984	2,080	40,035	19.25	12
13	Food Service Supervisor	5,621	5,621	65,087	11.58	13
14	Head Cook	5,655	6,635	79,037	11.91	14
15	Cook Helpers/Assistants	37,502	46,068	348,669	7.57	15
16	Dishwashers					16
17	Maintenance Workers	1,617	1,789	23,679	13.24	17
18	Housekeepers	40,705	47,279	378,802	8.01	18
19	Laundry	8,817	11,411	89,836	7.87	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,832	2,080	39,572	19.03	23
24	Clerical	8,685	9,968	110,282	11.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,783	2,254	21,035	9.33	31
32	Other Health Care(specify)					32
33	Other(specify)	7,460	8,933	101,209	11.33	33
34	TOTAL (lines 1 - 33)	359,252	434,809	$ 5,032,528 *	$ 11.57	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	223	$ 9,722	1-3	35
36	Medical Director	316	16,091	9-3	36
37	Medical Records Consultant	116	10,050	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,820	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	165	11-3	44
45	Social Service Consultant	8	375	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	667	$ 41,223		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	198	$ 6,380	10-3	50
51	Licensed Practical Nurses	2,443	76,750	10-3	51
52	Nurse Aides	5,906	133,342	10-3	52
53	TOTAL (lines 50 - 52)	8,547	$ 216,472		53

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Adult Day Care	7,460	8,933	$ 101,209	$ 11.33
	7,460	8,933	$ 101,209	$ 11.33

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
IMMC - Administrator	$ 118,800
IMMC - V/P of Finance	110,532
TOTAL (agree to Schedule V, line 17, col. 3)	$ 229,332
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Righeim, Martin & Cinquino	Legal Retainer	$ 7,400
KPMG	Audit	19,043
FR&R Healthcare Consulting Inc.	Healthcare Consulting	16,733
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 43,176

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	12,354
FICA Taxes	379,026
Employee Health Insurance	110,814
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
SEIU Union Pension Expense	30,463
Union Health and Welfare	66,362
TOTAL (agree to Schedule V, line 22, col.8)	$ 599,019

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	29,995
Health Care Worker Background Check	
(Indicate # of checks performed)	
Periodical Subscriptions	2,836
Advertising & Community Relations	16,530
Licenses and Dues	8,884
Less: Public Relations Expense	(8,765)
Non-allowable advertising	(7,765)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,715

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,464
IMMC Allocation - Therapy Dept. Seminars	3,870
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,334

**See instructions.

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Warren Barr Pavilion # 0046003 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Aides Only**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $8,884**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75,006** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **161,406**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **68,983**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **19,996**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not Finalized as of 10/31/00**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw